

Federal Healthcare Resilience Task Force

Alternate Care Site (ACS) Toolkit

Factsheet

Product Purpose:

This factsheet was developed to:

- Describe Alternate Care Strategies, Alternate Care Sites (ACS), and Federal Medical Stations (FMS) terminology;
- Provide an overview of the ACS Toolkit;
- Clarify potential funding solutions for establishment and operationalization of an ACS; and
- Outline options for preserving an ACS as a “warm site” and eligible costs available through FEMA Public Assistance.

Intended Audience:

State, Local, Tribal, and Territorial (SLTT) Entities

FEMA Regional Administrators

HHS Regional Administrators

Health care Systems



FEMA



FEMA Factsheet

Alternative Care Site (ACS) Toolkit

This factsheet describes Alternate Care Strategies, Alternate Care Sites (ACS) and Federal Medical Stations (FMS) terminology. This document will address options for preserving an ACS as a “warm site” and eligible costs available through FEMA Public Assistance.

- **Alternate Care Strategies**, which includes Alternate Care Sites, are intended to help provide additional health care capacity (e.g., beds) and capability (e.g., ventilators) for an affected community along the health care delivery spectrum (e.g., non-acute care, hospital care, acute care).
- **Alternate Care Site (ACS)** is a broad term for any building or structure of opportunity converted for health care use. It provides additional health care capacity (e.g., beds) and capability (e.g., ventilators) for an affected community, outside the walls of a traditional, established health care institution. An ACS can serve various patient types (e.g., COVID-19 or non-COVID-19) and purposes (e.g., non-acute care, hybrid care, or acute care). It can be established in many types of buildings (e.g., hotel or arena) to meet the local community’s needs. In all cases, the ACS will require significant logistical wraparound services, as well as appropriate medical staffing.
- **Federal Medical Station (FMS)** is a specific type of pre-packaged Alternate Care Site that is deployed, managed, and supported by the federal government out of the Strategic National Stockpile. In many past disasters, the FMS was a familiar entity provided by the federal government to impacted communities. In this pandemic, FMS represent a limited ACS capability and may not be available to meet every community’s needs. Therefore, other alternate care strategies need to be considered to establish increased health care capacity and capability during this pandemic.

Overview of Alternate Care Site (ACS) Toolkit

- The Third Edition of the ACS Toolkit provides augmented guidance based on feedback and experience with the national ACS mission. It builds upon, but does not change, basic tenets from the original guidance provided in the previous editions.
- Medical, operations, law enforcement, and construction experts from the U.S. government – U.S. Department of Health and Human Services (HHS), U.S. Marshal’s Service (USMS), and the U.S. Army Corps of Engineers (USACE) – developed this Toolkit as a best practices reference to support state, local, tribal, territorial entities in establishing and operationalizing an ACS. It provides “one good approach” that can be leveraged in total or in part.
- This Toolkit is structured around a Base Document, Appendices, Supplements, and a Checklist. The *Base Document* describes the foundational ACS framework to include establishment, operations, and closure of an ACS. The *Appendices* are supporting documents, tools, templates, and web links to support implementation of the foundational ACS framework. The *Supplements* describe guidance in detail pertaining to staffing and equipping the three different ACS Care Models based on level of care. The *Checklist* is a helpful quick reference for establishing, operating, and closing an ACS.
- The three ACS Care Models provide a framework for health care delivery based on level of care that is independent of facility type selected (e.g., arena, hotel, convention center) or overall setting (e.g., correctional setting, rural setting).



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- The **Non-Acute Care ACS Model** provides general, low-level patient care, corresponding to Level 5 (ambulatory care) and Level 4 (minor acuity care) patients in medical care terminology. This level of care for COVID-19 patients includes asymptomatic and/or mildly to moderately symptomatic patients that may require oxygen (up to 2L/min), but do not require extensive nursing care or assistance with Activities of Daily Living (ADL). This model also includes persons under investigation (PUI) being monitored for quarantine and/or isolation.
- The **Hybrid Care ACS Model** provides mid-level care, corresponding to Level 3 (medical-surgical care) patients in medical care terminology. This level of care for COVID-19 patients includes moderately symptomatic patients that may require oxygen (more than 2L/min), nursing care, or assistance with ADL.
 - Note: The name for this model has changed to “Hybrid Care ACS Model” from “Hospital Care ACS Model” to deconflict the term “hospital care” with the concept of a traditional hospital. The guidance surrounding this model remains unchanged.
- The **Acute Care ACS Model** provides higher acuity care, corresponding Level 2 (step-down care) and Level 1 (intensive care) patients in medical care terminology. This level of care for COVID-19 patients includes patients who require significant medical support, including intensive monitoring on a ventilator.

Key Takeaways for the ACS Toolkit

- **One of Many Options for Medical Surge:** An ACS is one of many options to address medical surge. The decision to establish an ACS should be considered in conjunction with the suite of other options available to meet medical surge needs such as telemedicine options and local and regional coordination mechanisms (e.g., targeted patient transfer, select workforce strategies).
- **Local Decision:** Decisions about the need for and type of ACS should be made by SLTT entities, and HHS and Federal Emergency Management Agency (FEMA) regional personnel can provide consultation on the approach.
- **Medical Operations Guidance:** This ACS Toolkit is medical operations guidance. It details the establishment, operations, and closure of an ACS. There are three ACS Care Models described in this document: Non-Acute Care, Hybrid Care, and Acute Care. Importantly, this guidance focuses on the delivery of health care for all patients impacted by this health care emergency (e.g., both pediatric and adult patients).
- **Medical Support Essential:** Given the potential for patient decompensation even at the non-acute care level, it is recommended there be medical support available at any ACS.
- **One Good Approach:** This Toolkit provides “one good approach” to configure Alternate Care Sites. All SLTTs are encouraged to adapt these principles to meet the specific needs of their community.
- **Fully Functional ACS:** To be considered fully functional, an ACS must include not only the facility (the space), but also the appropriate personnel (the staff) and medical equipment and supplies (the stuff) for health care delivery (the service). A key component of a functional ACS is a robust network of communication and coordination that ensures smooth transfer of patients within a community, as needed, for delivery of care.
- **Health Care Partnership:** An ACS should be established in partnership with existing and traditional health care organizations (the system) for both operational and funding reasons.
- **Warm Site Status:** Alternate Care Sites that remain operationally ready but unused (warm sites) will be an available surge capacity for COVID-19 readiness and response. It is recommended that SLTT entities retain their existing ACS locations for future COVID-19 outbreaks as warm sites.

Potential Funding Streams for Alternate Care Sites

- Funding solutions are unique to each SLTT entity based on a number of factors, including the funding objective and type of emergency declaration.
- The different ACS models and ownership options can affect funding availability/eligibility and sources, so understanding the options before making ACS ownership decisions is a critical step.
- SLTT entities may access several sources of federal funding to support establishing an ACS, for operation and ongoing administration of an ACS, and for direct patient care costs. The following grant programs may be accessed by eligible recipients to fund ACS related activities, subject to the terms and conditions of each individual grant program and award.
- For more information on funding sources, see the ACS Funding Summary: Establishment and Operationalization at: <https://files.asprtracie.hhs.gov/documents/aspr-tracie-acs-funding-sources-establishment-and-operationalization.pdf>
- **Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program – COVID-19 Emergency Supplemental Funding:** As part of COVID-19 emergency supplemental funding that was released beginning in March 2020, the ASPR's Hospital Preparedness Program (HPP) cooperative agreement recipients and subrecipients (e.g., health care coalitions, state and jurisdiction special pathogen treatment centers, and regional Ebola and other special pathogen treatment centers) and Hospital Association cooperative agreement recipients and subrecipients (hospitals and other related health care entities) may identify and operate an ACS to expand health care surge capacity for COVID-19, as these are allowable activities within HPP's COVID-19 emergency administrative supplement. Funding may pay for beds, equipment and supplies but cannot be used for clinical care or for staffing to provide clinical care. Also, funding under these awards may only be used for minor alteration and renovation (A&R) activities. Construction and major A&R activities are not permitted. For more information about these cooperative agreements, see the ASPR web page on HPP and COVID-19 Resources for Health Care System Preparedness and Response at: <https://www.phe.gov/emergency/events/COVID19/HPP/Pages/default.aspx>.
- The Centers for Disease Control and Prevention (CDC) Division of State and Local Readiness (DSLRL) is administering supplemental funding to SLTT entities to prevent, prepare for, and respond to COVID-19 through the **CDC Crisis Response Cooperative Agreement (Crisis COAG)**. Generally, funding is not intended to support clinical care except in limited cases regarding quarantine and isolation support. CDC COVID-19 funding may also support the provision of care in an ACS by paying for beds, equipment, and supplies, but cannot be used for personnel to provide clinical care in that setting. For additional information see CDC COVID-19 Funding at <https://www.cdc.gov/cpr/readiness/funding-covid.htm>.
- **Supporting Tribal Public Health Capacity in Coronavirus Preparedness and Response** is a grant intended to support tribes and tribal organizations in carrying out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities for COVID-19. Information on this grant can be found at: <https://www.grants.gov/web/grants/view-opportunity.html?oppld=325942>.
- The **Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement** exists to detect, respond to, control, and prevent infectious diseases. CDC has used this cooperative agreement to support specific activities at state, local and territorial health departments in their response to COVID-19. Information about the ELC cooperative agreement can be found at: <https://www.cdc.gov/ncezid/dpei/epidemiology-laboratory-capacity.html>.

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- SLTT entities operating an ACS should contact their applicable CMS Regional Office for additional information regarding participation in CMS programs. SLTT entities that are interested in being paid by Medicare, Medicaid / Children’s Health Insurance Program (CHIP) for the health care services furnished at the ACS should strongly consider partnering with local health care providers.
- **COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program** provides reimbursements on a rolling basis directly to eligible providers for claims that are attributed to the testing and treatment of COVID-19 for uninsured individuals. Information about the program can be found at: <https://www.hrsa.gov/coviduninsuredclaim>.
- The establishment and operation of an ACS by SLTT entities and certain private non-profit organizations (eligible applicants) to expand capacity for COVID-19 are eligible emergency protective measures under the **FEMA Public Assistance (PA) Program**. Eligible applicants may perform or contract for the work directly and seek reimbursement through PA or submit a resource request for Direct Federal Assistance (DFA) to FEMA through the state, tribe (if direct recipient) or territory. **Both options are cost shared**. For more information, please see Coronavirus (COVID-19) Pandemic: Medical Care Costs Eligible for Public Assistance at: https://www.fema.gov/media-library-data/1589208038530-19c77b9558076c303b4ebec5f0631697/PA_Medical_Care_Policy_for_COVID-19_508.pdf.

Preserving an ACS as a “Warm Site” and Eligible Costs Available Through FEMA Public Assistance

- A “warm site” is an ACS that remains operationally ready but unused in order to be available for surge capacity for COVID-19 readiness and response. It is recommended that SLTT entities retain their existing ACS locations for future COVID-19 outbreaks as warm sites. There are two options for retaining an ACS as a warm site:
 - Preserve-in-place: Retain existing ACS configured in its current location.
 - Store-to-surge: Disassemble site and store medical equipment for future rapid activation.
- HHS and FEMA regional personnel will work with SLTT entities to determine the best warm site options for individual communities as well as funding (e.g., specific assistance programs for warm site status) and logistical considerations (e.g., ongoing maintenance responsibilities).
- To address immediate and projected needs from the COVID-19 pandemic, SLTT entities may, under certain conditions, be reimbursed through FEMA’s Public Assistance Program for costs associated with keeping ACSs, including temporary and expanded medical facilities, minimally operational when COVID-19 cases diminish, and the facilities are no longer in use. Additional information on eligible costs to maintain ACSs as “warm sites” can be found at: <https://www.fema.gov/news-release/2020/05/12/coronavirus-covid-19-pandemic-alternate-care-site-ac-s-warm-sites>.

Acronym List

| Acronym | Literal Translation |
|-------------|---|
| A&R | Alternation and Renovation |
| ACS | Alternate Care Site |
| ADL | Activities of Daily Living |
| ASPR | Assistant Secretary for Preparedness and Response |
| CDC | Centers for Disease Control and Prevention |
| CHIP | Children's Health Insurance Program |
| COVID-19 | 2020 SARS-CoV2 virus |
| Crisis COAG | Crisis Response Cooperative Agreement |
| DFA | Direct Federal Assistance |
| DSLRL | Division of State and Local Readiness |
| ELC | Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases |
| FEMA | Federal Emergency Management Agency |
| FMS | Federal Medical Station |
| HHS | U.S. Department of Health and Human Services |
| HPP | Hospital Preparedness Program |
| PA | Public Assistance |
| PUI | Person Under Investigation |
| SLTT | State, Local, Tribal, and Territorial |
| USACE | U.S. Army Corps of Engineers |
| USMS | U.S. Marshal's Service |